

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 May 2006

In the Matter of

KENNETH R. DEAN
Claimant

Case No.: 2004 BLA 5656

v.

FLAT GAP MINING COMPANY, INC./
LIBERTY MUTUAL FIRE INSURANCE CO.
Employer/Insurer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS

Party in Interest

Appearances: Mr. Joseph E. Wolfe, Attorney
For the Claimant

Mr. H. Ashby Dickerson, Attorney
For the Employer/Insurer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER --
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. Kenneth R. Dean for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim (DX 1)¹

Initial Adjudication

Mr. Dean filed his first application for black lung disability benefits on February 28, 1983. After a pulmonary evaluation, a claims examiner for the U.S. Department of Labor (“DOL”) denied his claim for benefits on January 24, 1984 because Mr. Dean failed to prove the presence of pneumoconiosis or total disability. Following Mr. Dean’s appeal, the case was forwarded to the Office of Administrative Law Judges (“OALJ”) on June 26, 1985. Due to an unopposed request by an employer, Administrative Law Judge G. Marvin Bober returned the case file to the District Director on July 19, 1986 to further evaluate the responsible operator issue. On April 20, 1990, the District Director returned the case to OALJ. However, due to late notification of the proceedings to an insurer, Administrative Law Judge Clement J. Kichuk again returned the case to the District Director on September 11, 1991. On March 9, 1992, DOL returned the case to OALJ.

First Administrative Law Judge Adjudication

On October 29, 1992, Administrative Law Judge Eric Feirtag conducted a hearing with Mr. Dean. On March 18, 1993, Judge Feirtag denied Mr. Dean’s claim. Through application of the “true doubt” rule, Judge Feirtag determined the conflicting chest x-ray evidence established pneumoconiosis. However, the preponderance of the pulmonary examination results and medical opinion did not establish total disability. On March 28, 1993, Mr. Dean appealed the adverse decision.

Benefit Review Board Adjudication

On September 23, 1994, noting in part that the “true doubt” rule had recently been invalidated, the Benefit Review Board (“BRB”) vacated portions of Judge Feirtag’s findings and returned the case for further consideration.

Second Administrative Law Judge Adjudication

On remand, on January 10, 1995, Judge Feirtag determined the chest x-ray evidence was insufficient to establish the presence of pneumoconiosis. However, the preponderance of medical opinion established the presence of pneumoconiosis. Nevertheless, the medical record remained insufficient to establish total disability.

¹The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Modification

On November 28, 1995, Mr. Dean submitted a modification request and the results of a pulmonary function test. On December 18, 1995, the District Director denied the modification request because the pulmonary test results did not establish total disability and a corresponding change in conditions.

Second Claim (DX 2)

Initial Adjudication

On March 10, 1997, Mr. Dean filed his second claim for black lung disability benefits. On December 23, 1997, the District Director determined an award of benefits was appropriate. However, the Employer appealed on January 17, 1998 and the case was forwarded to OALJ on February 23, 1998.

Administrative Law Judge Adjudication

On June 17, 1998, Administrative Law Judge Jeffrey Tureck conducted a hearing with the parties. On December 4, 1998, Judge Tureck denied Mr. Dean's second claim because the medical evidence did not establish total disability. Mr. Dean appealed on December 30, 1998.

Benefit Review Board Adjudication

On March 8, 2000, the BRB affirmed Judge Tureck's denial of benefits.

Third Claim

On March 19, 2001, Mr. Dean filed his third, and present, claim (DX 3). On March 27, 2002, the District Director initially determined an award of benefits was warranted (DX 37). However, upon consideration of additional medical evidence, the District Director denied benefits on December 8, 2003 because Mr. Dean was not able to prove the presence of pneumoconiosis (DX 59). Mr. Dean appealed on December 29, 2003 (DX 61) and the case was forwarded to OALJ on January 21, 2004 (DX 65). Pursuant to a Notice of Hearing, dated November 24, 2004, (ALJ I), I conducted a hearing on March 16, 2005 in Abingdon, Virginia. Mr. Dean, Mr. Wolfe and Mr. Dickerson were present at the hearing.

Evidentiary Discussion

In his pre-hearing submissions, Claimant's counsel included a positive for pneumoconiosis interpretation by Dr. DePonte of a July 19, 2004 chest x-ray. However, at the hearing, counsel identified as the Claimant's two permissible case-in-chief chest x-rays, the evaluations by Dr. Patel of the June 2001 and June 2003 films. Additionally, since the Employer did not submit the July 19, 2004 film as part of its case-in-chief, Dr. DePonte's interpretation is

not admissible as rebuttal. Consequently, due to the evidentiary restrictions in 20 C.F.R. §§ 725.414 (a) (2) (i) and (ii), I am not permitted to consider Dr. DePonte's finding.

In partial response to Claimant's evidentiary presentation at the hearing, Employer's counsel withdrew several exhibits, including a rebuttal negative interpretation of the July 19, 2004 chest x-ray by Dr. Scott, marked as EX 4, to Dr. DePonte's positive finding. The inadmissibility of Dr. DePonte's positive finding and withdrawal of Dr. Scott's negative interpretation predictably produced an evidentiary problem under the new regulations because when Dr. Castle reviewed the entire medical record several months before the hearing, he considered these two interpretations which subsequently were not included in the record. In other words, while he didn't know it at the time, Dr. Castle considered inadmissible evidence during his review of all the objective medical evidence. While medically sound, such consideration is legally problematic because under 20 C.F.R. §§ 725.414 (a) (2) (i) and 3 (i) "any chest X-ray interpretation, pulmonary function test results, blood gas studies . . . and physician opinions that appear in a medical report must each be admissible . . ." under the regulations.

In *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1- ___, BRB No. 04-0812 BLA (Jan. 27, 2006) (en banc), the Benefits Review Board indicated that when confronted with a medical opinion that contained evidence not admitted into the formal record, an administrative law judge may: a) exclude the report; b) redact the objectionable content; c) require a revised report; or, d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report. In the present case, I will apply a combination of the second and fourth options. First, I will not include Dr. Castle's summarization of Dr. DePonte's and Dr. Scott's findings of the July 2004 chest x-ray when I consider the radiographic evidence. Second, since the two opinions were offsetting, I do not believe Dr. Castle's review of the two findings among the dozens of admissible interpretations would adversely affect the probative value of his opinion in regard to consideration of the medical record.

Finally, at the hearing, Employer's counsel withdrew EX 2 and EX 12 to EX 15. Additionally, in response to a CT scan submission by Claimant's counsel, I left the record open for 30 days to give the Employer an opportunity to respond. On April 25, 2005, I received from Employer's counsel an interpretation by Dr. Scatarige of a January 20, 2005 CT scan. I now admit that evidence as EX 16.

Accordingly, my decision in the case is based on the hearing testimony and the following documents admitted into evidence: DX 1 to DX 67, CX 1, EX 1, EX 3, EX 5 to EX 11, and EX 16.

ISSUES

1. Whether in filing a subsequent claim on March 19, 2001, Mr. Dean has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his most recent prior claim was based on March 8, 2000.
2. If Mr. Dean establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on September 10, 1926, Mr. Dean married Mrs. Marion C. Dean on December 4, 1953. Mr. Dean started mining coal in January 1948. Other than a one year break due to a tipple fire and a few weeks absence associated with contract disputes, Mr. Dean worked as a coal miner through May 1982 when the mine shut down. When his mining career ended, Mr. Dean was working as a section supervisor, which required significant walking to inspect mine conditions and heavy manual labor associated with lifting fifty pound rock dust bags. Mr. Dean started smoking cigarettes when he was fifteen (1941) and continued through the last part of 1986. During that period, he smoked cigarettes at the rate of a pack a day. At the time of his 1992 hearing, Mr. Dean was becoming out of breath with exertion (DX 1, DX 3, DX 7, and DX 9).

Issue #1 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim and adjudicated under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied (“applicable condition of entitlement”) has changed and is now present. 20 C.F.R. § 725.309 (d) (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

To receive black lung disability benefits under the Act, a claimant must prove four basic conditions, or elements, related to his physical condition. First, the miner must establish the presence of pneumoconiosis.² Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.³ Third, the miner has to demonstrate he is totally disabled.⁴ And fourth, the miner must prove the total disability is due to pneumoconiosis.⁵

Based on those four principle conditions of entitlement, the adjudication of a subsequent claim involves the identification of the condition(s) of entitlement a claimant failed to prove in the prior claim and then an evaluation of whether through newly developed evidence a claimant is able to now prove that condition(s) of entitlement. Mr. Dean's most recent, prior claim was finally denied in March 2000 for failure to prove that he is totally disabled from a respiratory standpoint. Consequently, for purposes of determining whether a change in conditions of entitlement has occurred, I will evaluate the evidence developed since the prior claim record closed in 1998 to determine whether Mr. Dean can now prove that he is totally disabled.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§ 718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a living miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corp. & Triangle Enterprises and Dir.*, *OWCP*, 49 F.3d 993 (3d Cir. 1995), the court stated, in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

The record does not contain sufficient evidence that Mr. Dean has complicated pneumoconiosis and he has not presented evidence of cor pulmonale with right-sided congestive

²20 C.F.R. § 718.202.

³20 C.F.R. § 718.203 (a).

⁴20 C.F.R. § 718.204 (b).

⁵20 C.F.R. § 718.204 (a).

heart failure. As a result, Mr. Dean must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	Date / Doctor	Age / Height	FEV ¹ pre ⁶ post ⁷	FVC pre post	MVV pre post	% FEV ¹ / FVC pre post	Qualified ⁸ pre Post	Comments
DX 9	Jun. 28, 2001 Dr. Rasmussen	74 65"	2.04	3.50	74	58%	No	Slight obstruction.
DX 15	Apr. 29, 2003 Dr. Rosenberg	76 66"	1.68 1.96	2.78 3.56	62 79	60% 55%	No	
DX 14	Jun. 23, 2003 Dr. Rasmussen	76 64"	2.02 2.02	3.30 3.60	63 79	61% 56%	No No	

None of the pulmonary function studies reached the regulatory thresholds for total disability. As a result, Mr. Dean is not able to establish that he is totally disabled through pulmonary function tests under 20 C.F.R. § 718.204 (b) (2) (i).

Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ² (rest) pCO ² (exercise)	pO ² (rest) pO ² (exercise)	Qualified ⁹	Comments
DX 9	Jun. 28, 2001 Dr. Rasmussen	31 31	66 51	Yes ¹⁰ Yes	Very marked impairment upon exercise.
DX 15	Apr. 29, 2003 Dr. Rosenberg	37.2	65.7	No ¹¹	
DX 14	Jun. 23, 2003 Dr. Rasmussen	32 32	59 51	Yes ¹² Yes	Very marked loss of lung function
EX 5	Oct. 27, 2004	33.5	75.1	No ¹³	

⁶Test result before administration of a bronchodilator.

⁷Test result following administration of a bronchodilator.

⁸Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%. The maximum age on the charts is 71

⁹To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO² level, the value of the coal miner's pO² must be equal to or less than corresponding pO² value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. Part 718.

¹⁰For the pCO² of 31, the qualifying pO² is 69, or less.

¹¹For the pCO² of 37, the qualifying pO² is 63 or less.

¹²For the pCO² of 32, the qualifying pO² is 68, or less.

¹³For the pCO² of 33, the qualifying pO² is 67, or less.

	Dr. Castle				
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Under 20 C.F.R. § 718.204 (b) (2) (ii), if the preponderance of blood gas studies qualify under Appendix C of Section 718, then in the absence of evidence to the contrary, the blood gas study evidence shall establish a miner's total respiratory disability.

This regulatory scheme requires a five step process. First, an administrative law judge must determine whether the tests conform to the blood gas study procedure requirements in 20 C.F.R. § 718.105. Second, the test results are compared to the pO_2 qualifying numbers listed in Appendix C to determine whether the tests show total disability. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. *See Vivian v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Circuit 1990). Fourth, a determination must be made whether the preponderance of the conforming and valid blood gas studies supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming blood gas tests establishes total disability under the regulation, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is then made to see if it outweighs the blood gas study evidence that supports a finding of total respiratory disability. *Fields v. Island Creek Coal Company*, 10 B.L.R. 1-19, 1-21 (1987) and *Milburn Colliery Co. v. Hicks*, 138 F.3d 524, 531 (4th Cir. 1998) (an administrative law judge must consider the potential effect of obesity, heart disease, and coronary artery surgery on the arterial blood gas tests).

All six blood gas studies appear to conform to the regulatory requirements. Four out of the six tests met the regulatory total disability threshold. Further, although only two of the four resting evaluations qualified for total disability, both exercise arterial blood gas test indicated that Mr. Dean was totally disabled. Since Mr. Dean's last job as a mine foreman involved occasional heavy manual labor, the exercise arterial blood gas studies are particularly probative of total disability because they establish his inability to properly oxygenate his blood while under physical stress. Because no physician has challenged the validity of the test procedures, I conclude that the preponderance of the conforming, valid arterial blood gas studies, including in particular the two exercise evaluations, establishes total disability under the regulations.

Next, I turn to the fifth step in the adjudication process and consider other medical evidence related to Mr. Dean's pulmonary/respiratory capacity for contrary evidence.

As discussed above, the pulmonary function tests failed to disclose the presence of a total pulmonary disability. However, the Benefits Review Board and the courts have noted that pulmonary function tests and arterial blood gas studies often have little correlation since they assess different aspects of pulmonary condition. *Gurule v Director, OWCP*, 2 B.L.R. 1-772, 1-777 (1979), *aff'd* 653 F.2d 1368 (10th Cir. 1981) and *Sheranko v. Jones and Laughlin Steel Corp.*, 6 B.L.R. 1-797, 1-798 (1984). As a result, the existence of non-qualifying pulmonary function tests does not represent sufficient contrary evidence to the qualifying blood gas studies.

Next, the radiographic evidence summarized later in this present claim, standing alone, does not provide contrary evidence since the chest x-rays do not establish the extent of disability.

Finally, all three physicians who recently evaluated Mr. Dean's respiratory condition between 2001 and 2004, Dr. Rasmussen, Dr. Rosenberg, and Dr. Castle, concluded that he was

totally disabled due to his impaired oxygen transfer capacity. Consequently, the medical opinion is consistent with, rather than contrary to, the preponderance of the multiple arterial blood gas studies showing total disability.

Accordingly, I conclude that Mr. Dean is totally disabled pursuant to the provisions of 20 C.F.R. §718.204 (b) (2) (ii).

Correspondingly, based on the preponderance of the recent valid and qualifying exercise arterial blood gas studies, and in the absence of sufficient contrary evidence, Mr. Dean has shown a material change in conditions by establishing an element of entitlement previously adjudicated against him in his most recent prior claim. As a result, under 20 C.F.R. § 725.309 (d), denial of his subsequent claim based is no longer appropriate. Instead, I will review the entire record to determine whether Mr. Dean is able to prove all four elements necessary for entitlement of benefits under the Act; thereby establishing that he is totally disabled due to coal workers' pneumoconiosis. As previously mentioned, during this process, according to 20 C.F.R. § 725.309 (d) (4), "no finding made in connection with the prior claim . . . shall be binding on any party in the adjudication of the subsequent claim."

Issue # 2 – Entitlement to Benefits

Again, to establish entitlement to black lung disability benefits under Act, Mr. Dean must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.¹⁴ The regulatory definitions include both clinical (medical) pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."¹⁵ The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. § 718.201 (b). As several courts have noted, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202 (a)(2)), regulatory presumption (§ 718.202 (a)(3)),¹⁶ and medical opinion (§ 718.202 (a)(4)). Since the

¹⁴20 C.F.R. § 718.201 (a).

¹⁵20 C.F.R. § 718.201 (a) (1) and (2) (emphasis added).

¹⁶If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3), a coal miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present

record does not contain any evidence the claimant has complicated pneumoconiosis, and Mr. Dean filed this claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. As a result, Mr. Dean will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. In addition, since Mr. Dean last labored as a coal miner in Virginia, under the guidance of *Compton*,¹⁷ I must consider the chest x-ray evidence and medical opinion together to determine whether he can establish pneumoconiosis.

Chest X-Ray Interpretations

Date of x-ray	Exhibit	Physician	Interpretation
Aug. 10, 1971	DX 1	Dr. Straughan	(Negative for pneumoconiosis) ¹⁸ Pulmonary congestion or pneumonitis.
Aug. 11, 1971	DX 1	Dr. Straughan	(Negative for pneumoconiosis) Pulmonary congestion.
Aug. 12, 1971	DX 1	Dr. Straughan	(Negative for pneumoconiosis) Pulmonary congestion.
Sep. 28, 1977	DX 1	Dr. Jones	Positive for pneumoconiosis, profusion category 2/2, ¹⁹ type p opacities. ²⁰

then there is an irrebuttable presumption the coal miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the coal miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

¹⁷See *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

¹⁸Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. See *Marra v. Consolidation Coal Co.* 7 BLR 1-216, 1-219 (1985).

¹⁹The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102 (b) (2001), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

²⁰There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, *RESPIRATORY DISEASES* 581 (3d ed. 1981).

(same)	DX 1	Dr. Wiot, B, BCR ²¹	Negative for pneumoconiosis.
(same)	DX 1	Dr. Felson, C, B, BCR	Completely negative.
(same)	DX 1	Dr. Wheeler, B, BCR	Completely negative.
(same)	DX 1	Dr. Morgan, B, BCR	Negative for pneumoconiosis.
Apr. 25, 1983	DX 1	Dr. Navani	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities.
(same)	DX 1	Dr. Gaziano, B	Completely negative.
(same)	DX 1	Dr. Felson, C, B, BCR	Completely negative.
(same)	DX 1	Dr. Wiot, B, BCR	Completely negative.
(same)	DX 1	Dr. Morgan, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wheeler, B, BCR	Completely negative.
May 31, 1983	DX 1	Dr. Stinnett	(Inconclusive for pneumoconiosis) ²² Pulmonary fibrosis throughout both lung fields.
(same)	DX. 1	Dr. Wiot, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Felson, C, B, BCR	Completely negative.
(same)	DX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type p opacities.
(same)	DX 1	Dr. Morgan, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type p/s opacities.
Apr. 11, 1984	DX 1	Dr. Westerfield, B	Positive for pneumoconiosis, profusion category 1/0, type q/t opacities.
(same)	DX 1	Dr. Felson, C, B, BCR	Completely negative.
(same)	DX 1	Dr. Spitz, B, BCR	Completely negative.
(same)	DX 1	Dr. Morgan, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wheeler, B, BCR	Completely negative.

²¹The following designations apply: C- C reader, B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “C Reader” designates only highly regarded individuals who developed the black lung classification system for chest x-rays and represents the highest interpreter qualification. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

²²Although Dr. Stinnett identified pulmonary fibrosis, he neither diagnosed pneumoconiosis nor provided profusion and opacity observations supportive of a finding of pneumoconiosis.

Oct. 18, 1985	DX 1	Dr. Scott, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wheeler, B, BCR	Completely negative.
(same)	DX 1	Dr. Wiot, B, BCR	Completely negative
(same)	DX 1	Dr. Spitz, B, BCR	Completely negative.
(same)	DX 1	Dr. DePonte, B, BCR	Positive for pneumoconiosis, profusion category 1/0, type p opacities.
Feb. 7, 1986	DX 1	Dr. Robinette, B	Positive for pneumoconiosis, profusion category 1/1, type q/p opacities.
(same)	DX 1	Dr. Bassham	(Inconclusive for pneumoconiosis) ²³ Interstitial pulmonary fibrosis present.
(same)	DX 1	Dr. Scott, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type q opacities.
(same)	DX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wiot, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Felson, C, B, BCR	Completely negative.
Sep. 30, 1986	DX 1	Dr. Byers, B	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities.
(same)	DX 1	Dr. Wheeler, B, BCR	Completely negative.
(same)	DX 1	Dr. Scott, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type s/p opacities.
(same)	DX	Dr. Felson, C, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Spitz, B, BCR	Negative for pneumoconiosis.
Jan. 13, 1987	DX 1	Dr. Westerfield, B	Positive for pneumoconiosis, profusion category 1/1, type q/t opacities.
(same)	DX 1	Dr. Spitz, B, BCR	Negative for pneumoconiosis; emphysema present.
(same)	DX 1	Dr. Wiot, B, BCR	Completely negative
(same)	DX 1	Dr. Scott, B, BCR	Negative for pneumoconiosis; emphysema present.
(same)	DX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wershba, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type s/t opacities; possible COPD (chronic obstructive pulmonary disease) present.
(same)	DX 1	Dr. Pendergrass, B, BCR	Negative for pneumoconiosis, profusion category 0/1, type s/p opacities.
Oct. 28, 1988	DX 1	Dr. Wiot, B, BCR	Negative for pneumoconiosis.

²³Dr. Bassham specifically indicated that he was not evaluating the film the film for the presence of “industrial pneumoconiosis.”

(same)	DX 1	Dr. Spitz, B, BCR	Completely negative.
(same)	DX 1	(Unreadable)	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.
(same)	DX 1	Dr. Wershba, B, BCR	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.
(same)	DX 1	Dr. Binns, B, BCR	Positive for pneumoconiosis, profusion category 1/0, type s/t opacities.
(same)	DX 1	(Unreadable)	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities.
(same)	DX 1	Dr. Vest	(Negative for pneumoconiosis) “Unremarkable except for some pleural thickening.”
(same)	DX 1	Dr. Scott, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
Jun. 25, 1991	DX 1	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Scott, B, BCR	Negative for pneumoconiosis.
(same)	DX 1	Dr. Fino, B	Completely negative.
(same)	DX 1	Dr. Spitz, B, BCR	Negative for pneumoconiosis.
Aug. 23, 1991	DX 1	Dr. Sargent, B	Positive for pneumoconiosis, profusion category 1/1, type t/q opacities.
(same)	DX 1	Dr. Mathur, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities.
Jul. 7, 1997	DX 2	Dr. Forehand, B	Positive for pneumoconiosis, profusion category 1/0, type q/t opacities.
(same)	DX 2	Dr. Gaziano, B	Positive for pneumoconiosis, profusion category 1/1, type q/t opacities.
(same)	DX 2	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scott, B, BCR	Negative for pneumoconiosis.
(same)	DX 2	Dr. Fino, B	Completely negative
Mar. 16, 1998	DX 2	Dr. Dahhan, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities.
(same)	DX 2	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scott, B, BCR	Negative for pneumoconiosis.
(same)	DX 2	Dr. Fino, B	Completely negative.
Jun. 28, 2001	DX 9	Dr. Patel, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type s opacities; mild chronic obstructive pulmonary disease present.
(same)	DX 16	Dr. Scott, B, BCR	Negative for pneumoconiosis.
Apr. 29, 2003	DX 15	Dr. Halbert, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities. Consistent

			with asbestosis.
Jun. 23, 2003	DX 14	Dr. Patel, B, BCR	Positive for pneumoconiosis, profusion category 1/1, type s opacities; emphysema present.
(same)	DX 17	Dr. Wheeler, B, BCR	Negative for pneumoconiosis.
Jan. 28, 2004	CX 1	Dr. Haines, BCR	(Inconclusive for pneumoconiosis) ²⁴ Chronic obstructive pulmonary disease and chronic interstitial changes present. (treatment x-ray).
Jan. 29, 2004	CX 1 & EX 11	Dr. Haines, BCR	(Inconclusive for pneumoconiosis) Chronic interstitial changes present; no acute infiltrates. (treatment x-ray).
Feb. 20, 2004	EX 3	Dr. Rao, BCR	(Negative for pneumoconiosis). COPD (chronic obstructive pulmonary disease) present; no acute lung abnormality (treatment x-ray).
Aug. 26, 2004	CX 1	Dr. Humphreys	(Inconclusive for pneumoconiosis) ²⁵ Pulmonary hyperinflation and chronic interstitial disease present. (treatment x-ray).
Oct. 27, 2004	EX 5	Dr. Wheeler, BCR, B	Negative for pneumoconiosis. Emphysema present.

Of the 24 chest x-rays in the record, no dispute exists concerning 11 of films. Based on uncontested interpretations, the following 6 films are negative for pneumoconiosis: August 10, 1971; August 11, 1971; August 12, 1971; June 25, 1991; February 20, 2004; and October 27, 2004. Similarly, the following 2 chest x-rays are positive for pneumoconiosis: August 23, 1991 and April 29, 2003. Finally, the next 3 films are inconclusive: January 28, 2004; January 29, 2004; and August 26, 2004.

Turning to the remaining 13 films, Dr. Jones found the September 28, 1977 chest x-ray positive for pneumoconiosis. However, his opinion is outweighed by the consensus of four dual qualified radiologists, Dr. Felson, Dr. Wiot, Dr. Wheeler, and Dr. Morgan, that the film is negative. As a result, I find the September 28, 1977 chest x-ray is negative for pneumoconiosis. For the same reason, while the names of the four to six concurring dual qualified radiologists changed somewhat, I find their negative consensus outweighs the singular positive/inconclusive contrary interpretations such that the chest x-rays of April 25, 1983; May 31, 1983; April 11, 1984; February 7, 1986; September 30, 1986; and, January 13, 1987 are also negative for pneumoconiosis.

In the October 18, 1985, chest x-ray, Dr. DePonte, also a dual qualified radiologist, found the presence of pneumoconiosis. Nevertheless, her expert opinion is outweighed by the consensus of four similarly well qualified radiologists, Dr. Scott, Dr. Wheeler, Dr. Wiot, and Dr. Spitz, which establishes that the film is negative for pneumoconiosis.

²⁴Although Dr. Haines identified interstitial changes, he neither diagnosed pneumoconiosis nor provided profusion and opacity observations supportive of a finding of pneumoconiosis.

²⁵Although Dr. Humphreys identified chronic interstitial changes, she neither diagnosed pneumoconiosis nor provided profusion and opacity observations supportive of a finding of pneumoconiosis.

Four physicians who evaluated the October 28, 1988 chest x-ray found evidence of pneumoconiosis. Unfortunately, I am unable to ascertain the qualifications of two of the doctors due to illegible names. Consequently, the four dual qualified radiologists, Dr. Spitz, Dr. Wiot, Dr. Scott, and Dr. Wheeler, who did not find pneumoconiosis in the film continue to prevail over Dr. Wershba and Dr. Binns, who are also dual qualified radiologists, and the other two unidentified physicians who believed the film was positive. As a result, the October 28, 1988 chest x-ray is negative for pneumoconiosis.

In the July 7, 1997 chest x-ray, Dr. Forehand and Dr. Gaziano, both B readers, saw pneumoconiosis. Dr. Wheeler and Dr. Scott, both dual qualified radiologists, considered the chest x-ray to be negative. Dr. Fino, another B reader also believed the study was negative. Since Dr. Wheeler and Dr. Scott have superior credentials,²⁶ their consensus is more probative than the opinion of the B readers. As a result, I find the July 7, 1997 film is negative for pneumoconiosis. For the same reason, the negative finding by Dr. Wheeler and Dr. Scott for the March 16, 1998 chest x-ray outweighs the contrary positive finding by Dr. Dahhan.

Finally, the professional standoff between two similarly well qualified radiologists Dr. Patel and Dr. Scott, renders the June 28, 2001 chest x-ray inconclusive for the presence of pneumoconiosis. The same medical stalemate exists between Dr. Patel and Dr. Wheeler in regards to June 23, 2003 radiographic study. As a result, the June 23, 2003 chest x-ray is also inconclusive.

Setting aside 5 inconclusive films (June 28, 2001; June 23, 2003; January 28, 2004; January 29, 2004; and, August 26, 2004) only 2 chest x-rays (August 23, 1991 and April 29, 2003) are positive for pneumoconiosis. The remaining 17 radiographic studies (August 10, 1971; August 11, 1971; August 12, 1971; September 28, 1977; April 25, 1983; May 31, 1983; April 11, 1984; October 18, 1985; February 7, 1986; September 30, 1986; January 13, 1987; October 28, 1988; June 25, 1991; July 7, 1997; March 16, 1998; February 20, 2004; and, October 27, 2004) are negative for pneumoconiosis. As a result, Mr. Dean is not able to establish the presence of pneumoconiosis through the preponderance of radiographic evidence under 20 C.F.R. § 718.202 (a) (1).

Medical Opinion

Although Mr. Dean cannot establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. § 718.202 (a) (4) through the preponderance of the more probative medical opinion. To better evaluate the diverse medical opinion, a review of the other objective medical evidence in the record is helpful.

²⁶The courts and Benefits Review Board have determined that it is proper to give greater probative weight to the interpretation of a dual qualified radiologist in comparison to a physician who is only a B reader. *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) and *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

Additional Pulmonary Function Tests²⁷

Exhibit	Date / Doctor	Age / Height	FEV ₁ pre ²⁸ post ²⁹	FVC pre post	MVV pre post	% FEV ₁ / FVC pre post	Qualified ³⁰ pre post	Comments
DX 1	Apr. 25, 1983 Dr. Paranthaman	56 66.25"	2.53	3.42	126	74%	No	
DX 1	Apr. 11, 1984 Dr. Smiddy	57 66"	2.71 2.82	4.05 4.18	124 105	66% 67%	No No	
DX 1	Feb. 7, 1986 Dr. Robinette	59 66"	2.67	3.68	114	72%	No	
DX 1	Sep. 30, 1986 Dr. Byers	60 65"	2.21 2.22	3.16 3.14	88 99	70% 70%	No No	
DX 1	Aug. 23, 1991 Dr. Sargent	65 ³¹ 65"	2.15 2.33	3.41 3.80	86	63% 61%	No No	
DX 2	Jul. 7, 1997 Dr. Forehand	70 64"	2.1	4.10	85	52%	No	
DX 2	Mar. 18, 1998 Dr. Dahhan	71 64.6" ³²	2.06 2.24	3.30 3.67	58 78	62% 61%	No No	

Additional Arterial Blood Gas Studies³³

Exhibit	Date / Doctor	pCO ₂ (rest) pCO ₂ (exercise)	pO ₂ (rest) pO ₂ (exercise)	Qualified	Comments
DX 1	Apr. 25, 1983 Dr. Paranthaman	39.6 37.3	72.4 62.1	No ³⁴ Yes	
DX 1	Apr. 11, 1984 Dr. Smiddy	36.4	72.4	No ³⁵	

²⁷The pulmonary function tests conducted between 2001 and 2003 have already been summarized.

²⁸Test result before administration of a bronchodilator.

²⁹Test result following administration of a bronchodilator.

³⁰Under 20 C.F.R. § 718.204 (b)(2)(i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV₁ must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV₁/FVC has to be equal to or less than 55%.

³¹The test form incorrectly lists Mr. Dean's age as 70.

³²Listed as 164 centimeters.

³³The arterial blood gas studies obtained from 2001 to 2004 have already been summarized and established a change in condition.

³⁴For a pCO₂ of 39, the qualifying pO₂ is 61, or less.

³⁵For a pCO₂ of 36, the qualifying pO₂ is 64, or less.

DX 1	Feb. 7, 1986 Dr. Robinette	32.7	65.2	Yes	
DX 1	Sep. 30, 1986 Dr. Byers	33.4	62.1	Yes	
DX 1	Aug. 23, 1991 Dr. Sargent	31.9	69.6	No	
DX 2	May 5, 1995 Dr. Kotay	32.7	71.3	No	
DX 2	Jul. 7, 1997 Dr. Forehand	31 31	62 56	Yes Yes	
DX 2	Mar. 18, 1998 Dr. Dahhan	32.2 33.6	69.2 74.2	No No	

CT Scan
(CX 1 and EX 16)

On January 20, 2005, Dr. G. Thomas Haines, board certified in diagnostic radiology,³⁶ conducted a CT scan of Mr. Dean's chest. Mr. Dean had a clinical history of shortness of breath. According to the radiologist, the imaging revealed heavy coronary artery calcification. In both lungs, Dr. Haines observed, "changes of chronic obstructive pulmonary disease with emphysematous changes . . . [and] small fine nodularity throughout both lung fields with slightly coarser changes in the bases." Based on his study, Dr. Haines diagnosed chronic obstructive pulmonary disease with mild chronic interstitial disease "as described of nonspecific character."

Dr. John C. Scatarige, a board certified radiologist,³⁷ also evaluated the January 20, 2005 CT scan and found no evidence of coal workers' pneumoconiosis. The CT scan showed the presence of moderate, diffuse centrilobular emphysema and calcification of coronary arteries associated with coronary artery disease.

Medical Treatment Records³⁸
(DX 1, CX 1 and EX 5 to EX 11)

Between 1980 and 1988, Mr. Dean was treated by several physicians, including Dr. Miranda and Dr. Vest, for abdominal pain and underwent surgical procedures to address his problems. The medical histories indicated that he had coal workers' pneumoconiosis with exertional shortness of breath. His social histories included a significant record of cigarette smoking.

On January 28, 2004, Mr. Dean was admitted to the hospital following his presentation at the emergency room with chest pain. The admission diagnoses included myocardial infarction and coal workers' pneumoconiosis. Upon examination, the lungs had good air entry. Mr. Dean

³⁶As I informed the parties at the hearing (TR, page 7-8), I take judicial notice of Dr. Haines' board certification and have attached the certification documentation.

³⁷I take judicial notice of Dr. Scatarige's board certification and have attached the certification documentation.

³⁸I have only summarized the medical records associated with Mr. Dean's cardio-pulmonary condition.

ran a high fever and a chest x-ray was suggestive of right lower lobe pneumonia. From January 29 through February 20, 2004, Mr. Dean was treated by several physicians³⁹ for multiple ailments including “severe three vessel coronary artery disease.” Occasionally, his breath sounds were diminished. However, the chest x-rays did not show any acute process. During this period, Mr. Dean underwent a cardiac stent implantation.

Dr. S. K. Paranthaman
(DX 1)

On April 25, 1983, Dr. Paranthaman evaluated Mr. Dean’s pulmonary condition. Mr. Dean had 32 years of coal mine employment and smoked a pack of cigarettes a day for 25 years. His principle complaint was a persistent cough. The chest x-ray was positive for pneumoconiosis. The pulmonary tests showed an airflow obstruction and a moderate functional impairment in oxygen transfer due to coal workers’ pneumoconiosis. Dr. Paranthaman diagnosed coal workers’ pneumoconiosis and chronic bronchitis.

Dr. Joseph F. Smiddy
(DX 1)

On April 11, 1984, Dr. Smiddy evaluated Mr. Dean’s pulmonary health. Mr. Dean had 32 years of coal mine employment and 30 years of smoking cigarettes at the rate of one pack per day. He complained about shortness of breath. Upon physical examination, Dr. Smiddy noted decreased breath sounds. The chest x-ray was positive. The pulmonary function test indicated a mild obstruction and the arterial blood gas study showed low oxygen transfer at rest. Based on his examination, Dr. Smiddy diagnosed coal workers’ pneumoconiosis and he determined Mr. Dean was totally disabled.

Dr. Emory Robinette
(DX 1)

On February 7, 1986, Dr. Robinette, board certified in pulmonary and internal medicine, examined Mr. Dean, who had worked as a coal miner for 32 years and smoked cigarettes at the rate of a pack a day for 45 years. Mr. Dean had been experiencing increasing shortness of breath with exercise. Upon physical examination, Dr. Robinette hearing bilateral expiratory wheezes. The chest x-ray was positive for pneumoconiosis. The pulmonary function test was normal with impaired diffusion. The arterial blood gas study indicated mild resting hypoxemia. Considering the chest x-ray evidence, mild air trapping and diffusion impairment, Dr. Robinette diagnosed coal workers’ pneumoconiosis. The physician also believed Mr. Dean would experience “excessive” shortness of breath with exertion. Consequently, Mr. Dean could not return to his former coal mine employment. Dr. Robinette also advised Mr. Dean to stop smoking cigarettes.

³⁹Dr. Shahab Ehtesham, Dr. Brian Armstrong, Dr. Cary Meyers, Dr. Jeffrey Kappa, and Dr. Shamly Dhiman.

Dr. John G. Byers
(DX 1)

On September 30, 1986, Dr. Byers, board certified in pulmonary and internal medicine, conducted a pulmonary examination. Mr. Dean had mined coal for 33 years. His cigarette smoking history amounted to 47 pack years.⁴⁰ He had experienced several years of exertional dyspnea and periodic chest pain. Upon physical examination, Dr. Byers heard scattered rales. The chest x-ray was positive for pneumoconiosis. The pulmonary function test indicated a mild obstructive impairment due Mr. Dean's cigarette smoke-induced chronic bronchitis. The arterial blood gas study showed moderately severe hypoxemia due to cigarette smoking rather than exposure to coal dust. Dr. Byers believed that if Mr. Dean stopped smoking cigarettes he would experience a significant improvement in his breathing impairment. His pulmonary impairment prevented substantial or sustained exercise.

Dr. J. Dale Sargent
(DX 1)

On August 23, 1991, Dr. Sargent, board certified in pulmonary disease and internal medicine, examined Mr. Dean. Mr. Dean's coal mine employment covered 33 years and he had smoked a pack of cigarettes a day for 45 years. He complained about shortness of breath upon exertion. Upon physical examination, Dr. Sargent heard some wheezing with forced expiration. The chest x-ray was positive for pneumoconiosis. The pulmonary function test showed a "very mild ventilatory impairment" which improved slightly with bronchodilator use. The arterial blood gas study showed a "mild" abnormality. Dr. Sargent attributed the impairment to cigarette smoke because coal causes a mix of obstructive and restrictive impairment whereas cigarette smoking produces an obstructive impairment. The physician did not believe the impairment would preclude Mr. Dean from returning to coal mine employment. Based on the chest x-ray, Mr. Dean had simple pneumoconiosis. However, Dr. Sargent indicated that a diagnosis of coal workers' pneumoconiosis was equivocal. He noted that the "t" opacities in the lower lung zones were not abnormalities usually found with pneumoconiosis. Instead, those opacities were more consistent with cigarette smoke. Mr. Dean also had chronic bronchitis attributable to cigarette smoking.

Dr. Gregory J. Fino
(DX 1)

On October 5, 1992, Dr. Fino, board certified in pulmonary disease and internal medicine, reviewed Mr. Dean's medical record from 1971 through 1992, which included several pulmonary function studies and numerous x-ray interpretations. Based on his review, and for several reasons, Dr. Fino opined Mr. Dean did not have coal workers' pneumoconiosis. First, though some disagreement clearly existed, the majority of the chest x-rays were negative for pneumoconiosis. Second, the pulmonary function tests indicated the presence of an obstructive impairment without a restrictive defect. That pattern was most consistent with cigarette smoking and pulmonary emphysema, rather than coal dust exposure. Third, the pulmonary function tests also showed that Mr. Dean had normal diffusion and his diffusion capacity improved when he

⁴⁰A pack year represents the consumption of one pack of cigarettes per day for one year.

stopped smoking cigarettes which rules out clinically significant pulmonary fibrosis. Fourth, Mr. Dean did not have an oxygen transfer impairment with exercise. In conclusion, Dr. Fino also observed that even if Mr. Dean had coal workers' pneumoconiosis, he did not have a disabling respiratory impairment and retained the pulmonary capacity to return to his former coal mine employment.

Dr. Peter G. Tutuer
(DX 1)

On October 5, 1992, Dr. Tutuer, board certified in pulmonary disease and internal medicine, reviewed Mr. Dean's medical record from 1971 through 1991. Noting Mr. Dean's principal health issue had been his peptic ulcer and that the objective pulmonary tests established the presence of an obstructive pulmonary disease, Dr. Tutuer opined, "the clinical picture is most compatible with cigarette-smoke-induced chronic bronchitis, aggravated by recurrent aspiration associated with GERD." Dr. Tutuer observed that Mr. Dean's pulmonary symptoms waxed and waned and that Mr. Dean did not have a restrictive pulmonary defect or persistent impairment of oxygen exchange with exercise. Dr. Tutuer concluded Mr. Dean did not have coal workers' pneumoconiosis and his mild respiratory impairment consisting of a mild obstructive defect would not prevent his return to coal mining.

Dr. J. Randolph Forehand
(DX 2)

On July 17, 1997, Dr. Forehand, board certified in allergy, immunology, and pediatrics,⁴¹ examined Mr. Dean. Mr. Dean had worked 33 years in coal mines. He had also smoked cigarettes for 40 years at the rate of a pack a day. He complained about constant shortness of breath. The physical examination of the chest was normal. The chest x-ray was positive for pneumoconiosis. The pulmonary function test indicated an obstructive ventilatory pattern. The arterial blood gas study indicated hypoxemia. Based on the examination, Dr. Forehand diagnosed coal workers' pneumoconiosis and chronic bronchitis attributable to both coal dust and cigarette smoke. According to the arterial blood gas study, Mr. Dean had insufficient gas transfer capability to return to coal mine employment. Dr. Forehand believed both coal dust exposure and cigarette smoking "work in concert to impair respiratory function." In Mr. Dean's case, the presence of hypoxemia "coexisting with mild obstruction suggest CWP [is] as important as cigarette smoking in the genesis of claimant's disability."

Dr. A. Dahhan
(DX 2)

On March 18, 1998, Dr. Dahhan, board certified in pulmonary and internal medicine, conducted a pulmonary examination. Mr. Dean had mined coal for 33 years and smoked a pack of cigarettes a day for 45 years. Upon physical examination, the physician heard a slight prolongation upon expiration. The arterial blood gas study was normal, with hyperventilation. The pulmonary function test showed a mild partially reversible ventilatory defect. The chest x-ray indicated the presence of simple coal workers' pneumoconiosis. Dr. Dahhan also reviewed

⁴¹I take judicial notice of Dr. Forehand's board certification and have attached the certification documentation.

the medical record and pulmonary examinations from 1971 to the date of his exam. Based on his examination and record review, Dr. Dahhan opined that Mr. Dean had coal workers' pneumoconiosis. However, in light of the normal arterial blood gas studies and the mild obstruction, Mr. Dean was not totally disabled. Additionally, the obstructive defect was not due to coal dust exposure in part because a) the defect showed significant reversibility which is inconsistent with the permanent adverse effects of coal dust exposure; and, b) Mr. Dean did not have focal emphysema that is secondary to coal workers' pneumoconiosis.

Dr. D. L. Rasmussen
(DX 9, DX 10, DX 13, DX 14)

On June 28, 2001, Dr. Rasmussen, board certified in internal medicine, conducted a pulmonary examination. Mr. Dean had over 32 years of coal mine employment. His last work as a coal miner supervisor involved heavy manual labor. Mr. Dean smoked cigarettes from 1941 to 1986 at the rate of one pack per day. He complained about long term shortness of breath. Upon physical examination, Dr. Rasmussen heard reduced breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function tests indicated the presence of a slight obstructive impairment. The arterial blood gas study showed a very marked impairment in oxygen transfer upon exercise. Based on Mr. Dean's long history of coal mine employment and the chest x-ray, Dr. Rasmussen diagnosed coal workers' pneumoconiosis. Dr. Rasmussen also diagnose chronic bronchitis due to cigarette smoke and coal dust. Mr. Dean was totally disabled due to a marked loss of lung function. As possible etiologies, Dr. Rasmussen noted that Mr. Dean had two pulmonary risk factors: cigarette smoke and coal dust. According to the physician, Mr. Dean's "coal mine dust exposure is the predominant factor in view of his much greater impairment in gas exchange than in ventilatory capacity."

On June 23, 2003, Dr. Rasmussen conducted a second pulmonary examination. Mr. Dean's coal mine employment cover more than 30 years. He had smoked a pack of cigarettes a day from 1943 to 1986. The physical examination revealed moderately to markedly reduced breath sounds. The chest x-ray was positive for pneumoconiosis. The pulmonary function test showed a slight obstruction. The resting arterial blood gas study indicated moderate hypoxemia. Upon exercise, Mr. Dean became "markedly hypoxic." Mr. Dean was totally disabled due to a "very marked loss of lung function." The causes of his totally disabling lung disease were cigarette smoking and coal mine dust exposure. Both factors contributed to the impairment. However, coal mine dust was the major contributor. According to Dr. Rasmussen, both pulmonary irritants cause obstructive pulmonary disease. However, coal mine dust causes interstitial fibrosis and emphysema which leads to significant impairment in oxygen transfer absent significant ventilatory impairment.

Dr. David M. Rosenberg
(DX 15)

On April 29, 2003, Dr. Rosenberg, board certified in pulmonary and internal medicine, conducted a pulmonary examination. Mr. Dean had more than 30 years of coal mine employment and smoked cigarettes at the rate of a pack a day since he was 16 years old through 1986. He complained about long term shortness of breath with exertion. The physical

examination of the chest was normal. The pulmonary function test indicated an airflow obstruction with air trapping and a significant response to bronchodilators. The rest blood gas test did not meet the total disability thresholds; however, having reviewed Dr. Rasmussen's April 2001 pulmonary examination, Dr. Rosenberg indicated earlier exercise blood gas tests showed a disabling gas transfer abnormality. Although the chest x-ray opacity profusion was 1, Dr. Rosenberg did not believe it was indicative of pneumoconiosis because the opacities were in the lower two lung zones rather than the upper lung zones. As a result, based on the entire examination and noting that the marked bronchodilator response was inconsistent with the "fixed disease" of coal workers' pneumoconiosis, Dr. Rosenberg concluded although Mr. Dean had "some sort of interstitial involvement and airflow obstruction, he does not have the interstitial form of coal workers' pneumoconiosis." Mr. Dean's airways obstruction was manageable with bronchodilators. However, past exercise blood gas studies showed gas exchange abnormalities with exercise. As a result, Dr. Rosenberg believed Mr. Dean was totally disabled. This respiratory disability was not related to his coal mine employment. Instead, the impairment was caused by "basilar linear interstitial involvement" which can be caused by cigarette smoking. "Additionally, basilar opacities can relate to conditions such as idiopathic pulmonary fibrosis."

Dr. Rosenberg also reviewed Mr. Dean's medical record from 1971 through 2001, which included Dr. Rasmussen's most recent pulmonary examination. According to Dr. Rosenberg, "[w]hen all the above information is looked at in total, while Mr. Dean has some sort of interstitial involvement and airflow obstruction, he does not have the interstitial form of coal workers' pneumoconiosis (CWP)." Consequently, Mr. Dean's gas exchange disability was not attributable to coal dust inhalation; whereas, cigarette smoking can cause that type of interstitial lung disease. Dr. Rosenberg acknowledged that coal dust can cause COPD. However, such an obstructive lung disease begins with focal emphysema and Mr. Dean's chest x-ray does not show the micronodularity associated with focal emphysema. Thus, Dr. Rosenberg stated:

It would be improbable that his obstructive lung disease relates to the past inhalation of coal mine dust. Also the marked bronchodilator response is not consistent with the fixed disease of CWP. It should be emphasized that Mr. Dean's upper lobe emphysematous changes with a decreased diffusing capacity and air trapping are consistent with smoking-related COPD.

Dr. James R. Castle
(EX 5)

On October 27, 2004, Dr. Castle, board certified in pulmonary disease and internal medicine,⁴² evaluated Mr. Dean's pulmonary health. Mr. Dean had worked as a coal miner for over 30 years and his last job involved some heavy labor. He also had a 45 pack year history of cigarette smoking. His presenting health complaints included chronic shortness of breath and recurrent chest pain. His medical history disclosed coronary artery disease and surgery in February 2004 to insert a cardiac stent. Upon physical examination, Dr. Castle heard diminished breath sounds. The chest x-ray was negative for pneumoconiosis and showed the presence of emphysema. The resting arterial blood gas study was normal. Due to chest pains, Mr. Dean declined pulmonary function tests and an exercise arterial blood gas study. Dr. Castle

⁴²I take judicial notice of Dr. Castle's board certification and have attached the certification documentation.

concluded Mr. Dean did not have coal workers' pneumoconiosis. Noting prior exercise arterial blood gas studies were abnormal, Dr. Castle also opined Mr. Dean no longer possessed the respiratory capacity to return to coal mine employment.

Dr. Castle also reviewed the medical record and pulmonary evidence concerning Mr. Dean from 1971 through 2004. Mr. Dean faced three cardio-pulmonary risk factors consisting of 33 years of coal dust inhalation, a 45 pack year history of cigarette smoking, and cardiac artery disease. However, for several reasons, Dr. Castle concluded Mr. Dean did not have coal workers' pneumoconiosis. First, the extensive record did not contain consistent physical findings for an interstitial pulmonary process. The physical findings of reduced breath sounds were consistent with cigarette smoking. Second, the preponderance of the radiographic evidence was negative for pneumoconiosis. Third, the pulmonary function test results were inconsistent with pneumoconiosis. Mr. Dean's tests showed "a moderate degree of airway obstruction, with a significant degree of reversibility associated with normal total lung capacity, gas trapping, and reduction in diffusing capacity which is due to his tobacco smoke induced chronic obstructive pulmonary disease." In contrast, when pneumoconiosis causes an impairment, the pulmonary test will show "a mixed, irreversible obstructive and restrictive ventilatory impairment." Fourth, the variability in Mr. Dean's arterial blood gas studies is due to ventilation/perfusion ratio changes caused by tobacco smoke induced airways obstruction. Mr. Dean is totally disabled due to his COPD caused by cigarette smoking. Finally, even if he had simple coal workers' pneumoconiosis, he would not be disabled by the disease because the medical record does not contain the physiologic changes associated with a pulmonary disability caused by coal workers' pneumoconiosis.

Discussion

In a manner similar to the interpretation of the radiographic evidence, the numerous well qualified medical experts who evaluated Mr. Dean's pulmonary condition reached contrary conclusions on whether pneumoconiosis is present in his lungs. Due to this conflict in medical opinion, I must first assess the relative probative value of each respective opinion in terms of documentation and reasoning.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's

conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

With these principles in mind, I first turn to Mr. Dean's treatment records and the inclusion of coal workers' pneumoconiosis in his medical histories by Dr. Miranda, Dr. Vest, and other attending physicians during his 2004 cardiac hospitalization. Since neither the underlying documentation supporting that diagnosis is referenced in the medical histories nor the physicians provided an explanation for recording the presence of black lung disease, the medical history annotations do not provide probative evidence of pneumoconiosis. I also note that when Dr. Vest reviewed a October 28, 1988 chest x-ray, he observed no abnormalities other than pleural thickening. Likewise, the radiographic evidence associated with the 2004 hospitalization was at best inconclusive for the presence of pneumoconiosis.

Next, Dr. Paranthaman concluded that Mr. Dean had coal workers' pneumoconiosis. However, since Dr. Paranthaman did not specifically identify the basis for his determination, it has diminished probative value in regards to clinical pneumoconiosis to the extent it was based on incorrect documentation. That is, Dr. Paranthaman believed the chest x-ray evidence was positive for pneumoconiosis. However, I have determined the preponderance of the chest x-ray evidence is actually negative for pneumoconiosis. In terms of legal pneumoconiosis, Dr. Paranthaman's assessment is also not very well reasoned because he provide no explanation for his diagnosis and thus did not indicate the features of the objective medical evidence that supported his diagnosis. Further, Dr. Paranthman did not discuss the effect Mr. Dean's significant cigarette smoking history may have had on any pulmonary impairment.

For similar documentary and reasoning concerns, Dr. Smiddy's diagnosis of clinical pneumoconiosis has diminished probative value. Dr. Smiddy did not indicate the extent to which he based his determination on his incorrect belief that the radiographic evidence showed the presence of pneumoconiosis. Likewise, he neither identified how the other medical evidence establishes legal pneumoconiosis as the cause of Mr. Dean's pulmonary impairment nor correspondingly addressed the impact of Mr. Dean's decades-long pack a day cigarette smoking habit.

Again, to the extent Dr. Robinette rendered a diagnosis of clinical pneumoconiosis based on a positive chest x-ray, it has little probative value. Dr. Robinette also presented a finding of legal pneumoconiosis additionally noting a normal pulmonary function test, identifying the pattern of mild air trapping and diffusion impairment, and suggesting Mr. Dean would experience shortness of breath upon exertion. Though based on a significantly dated pulmonary examination, Dr. Robinette's reasoning continued to be supported with subsequent testing in the following years. Nevertheless, his opinion is not completely reasoned because he did not specifically address whether cigarette smoking might produce similar test results. His silence on Mr. Dean's second significant pulmonary risk factor and its effect on the test results is notable considering his advice to Mr. Dean that he stop smoking cigarettes.

For the reason previously discussed, Dr. Byers' finding of clinical pneumoconiosis based on the positive chest x-ray has little probative value. In a reverse mirror image of Dr. Robinette's discussion on legal pneumoconiosis, Dr. Byers identified the pattern of the objective

medical tests as the basis for his finding that cigarette smoking caused Mr. Dean's pulmonary impairment. In making his analysis, Dr. Byers did not discuss the extent to which Mr. Dean's decades-long exposure to coal dust might also have produced abnormal pulmonary test results. Thus, his failure to provide some differentiation basis for identifying cigarette smoke rather than, or with, coal dust as an impairment etiology diminishes the probative value of his assessment.

In addition to his stated equivocation, Dr. Sargent's finding of clinical pneumoconiosis has little probative value since it's based on a positive chest x-ray which is inconsistent with the preponderance of the radiographic evidence. In view of the evidence before him, and expressing the basis for his differentiation between the two significant pulmonary risk factors, Dr. Sargent's identification of cigarette smoking rather than exposure to coal dust is reasoned. However, his determination that Mr. Dean does not have legal pneumoconiosis has diminished probative value due to a significant documentation shortfall associated with the dated nature of his examination. When Dr. Sargent assessed Mr. Dean's oxygen transfer capacity in 1991, he only found a "mild" abnormality. Significantly, the more recent arterial blood gas studies showed a marked loss of oxygen transfer capacity upon exertion. Thus, Dr. Sargent's assessment is based, in part, on stale arterial blood gas test results and an incorrect belief that Mr. Dean is not totally disabled.

In a similar manner, Dr. Fino's conclusion that Mr. Dean does not have a pulmonary impairment due coal dust exposure has diminished probative weight due to the dated nature of medical tests upon which he based his opinion. In a reasoned opinion explaining how he was able to identify cigarette smoke rather than coal dust as the cause of Mr. Dean's obstructive impairment, Dr. Fino emphasized that Mr. Dean did not have an oxygen transfer impairment with exercise. The physician also noted that Mr. Dean did not have a significant pulmonary impairment. However, the most recent arterial blood gas studies show that Mr. Dean now has a significant oxygenation impairment that is totally disabling. Thus, Dr. Fino's opinion rests in part on incorrect documentation.

Dr. Tutuer also considered dated pulmonary test results in determining Mr. Dean did not have coal workers' pneumoconiosis which diminishes the probative value of his opinion. Specifically, as one differentiation basis for concluding cigarette smoke was the cause of Mr. Dean's mild impairment, Dr. Tutuer noted the absence of persistent impairment of oxygen exchange with exercise. To the contrary, Mr. Dean's oxygen exchange impairment with exercise has become both persistent and totally disabling.

Again, since the preponderance of the radiographic evidence is negative for pneumoconiosis, Dr. Forehand's finding of clinical pneumoconiosis has little probative value. At the same time, based on the other medical evidence before him, Dr. Forehand presented a reasoned opinion attributing both significant pulmonary risk factors, cigarette smoke and coal dust, as the co-existing causes of Mr. Dean breathing impairment, which supports a finding of legal pneumoconiosis. However, in light of subsequent pulmonary function tests, Dr. Forehand's etiology conclusion is based on incomplete documentation. When he conducted the pulmonary function test in 1997, Dr. Forehand only administered the pre-bronchodilator test. Less than a year later, another pulmonary function test included a post-bronchodilator test which showed an improvement in pulmonary functions due to the medication. Absent knowledge of the post-bronchodilator test results, Dr. Forehand was not able to consider how a demonstrated

reversibility of Mr. Dean's obstructive impairment may or may not have affected his conclusion that coal dust exposure was a co-existing cause of Mr. Dean's impairment.

Based specifically on his positive interpretation of March 18, 1998 chest x-ray, Dr. Dahhan diagnosed clinical pneumoconiosis. In light of the interpretations of better qualified radiologists, I have determined that particular x-ray, as well as the preponderance of the chest x-rays, is actually negative for black lung disease. As result, Dr. Dahhan's finding of clinical pneumoconiosis has little probative value. Despite his finding of clinical pneumoconiosis, Dr. Dahhan nevertheless presented a reasoned assessment about the absence of legal pneumoconiosis in light of the other medical tests. However, one of the documentary basis for his conclusion was a normal arterial blood gas tests and the absence of a totally disabling pulmonary impairment. Due to the dated, and now incorrect, documentation, Dr. Dahhan opinion about the presence of legal pneumoconiosis has diminished probative value.

As should be readily apparent by now, Dr. Rasmussen's finding of clinical pneumoconiosis based on positive chest x-rays and history of coal mine employment has little probative weight since the chest x-ray evidence is negative rather than positive for pneumoconiosis. Concerning the presence of legal pneumoconiosis, Dr. Rasmussen presented a well reasoned assessment explaining the basis for his determination that while both pulmonary risk factors have affected Mr. Dean's pulmonary functions, the pattern of an obstructive impairment, coupled with marked hypoxemia upon exercise establishes that coal dust was "the major contributor." His finding of legal pneumoconiosis is documented based on the two pulmonary examinations, including a pulmonary function test which did not show significant reversibility with use of bronchodilators. However, because he didn't review other pulmonary examinations, Dr. Rasmussen apparently was unaware of another pulmonary function test administered just a few months before his evaluation which did show a significant response to bronchodilator. Since Dr. Rasmussen attributed Mr. Dean's impairment to both pulmonary risk factors, the absence of any discussion about response to bronchodilator does not necessarily impeach his legal pneumoconiosis diagnosis. At the same time, having based his diagnosis solely on the results of his examinations, Dr. Rasmussen's assessment is not as well documented as other medical experts who evaluated all the medical evidence.

One last time, to the extent Dr. Rosenberg's belief that the chest x-ray evidence showed a profusion of "1" which might support a finding of clinical pneumoconiosis, his opinion about identifiable profusion has little probative value on the issue of clinical pneumoconiosis because the preponderance of the radiographic evidence is negative for pneumoconiosis. In contrast, based on both a pulmonary examination and a review of the entire medical record, Dr. Rosenberg presented a reasoned and very well documented opinion that Mr. Dean did not have legal pneumoconiosis. Dr. Rosenberg set out in detail the factors he relied upon to conclude cigarette smoke and not coal dust caused Mr. Dean's impairment, which included reversibility of the obstructive impairment upon use of bronchodilators and the absence of evidence of focal emphysema. At the same time, Dr. Rosenberg's conclusion is not completely documented because he was unaware of Dr. Rasmussen's pulmonary function test a few months later which did not show a significant post-bronchodilator response.

Finally, Dr. Castle presented a well reasoned analysis about the cause of Mr. Dean's pulmonary impairment. As the sole physician to review the entire medical record, including all the pulmonary examinations, he also had the best documented opinion. Based on the complete documentation, Dr. Castle was also the sole physician to note Mr. Dean's cardiac stent operation in February 2004 and identify cardiac disease as a third cardio-pulmonary risk factor. With the one exception of an incomplete consideration of the variability in the post-bronchodilator test results, the factors Dr. Castle identified upon which he isolated cigarette smoking as the cause of Mr. Dean's pulmonary impairment generally were the most consistent with all the objective medical evidence in the record.

In summary, since the preponderance of radiographic evidence is negative for pneumoconiosis, the various physician diagnoses of clinical pneumoconiosis have no documentary support and are not probative. For numerous documentation and reasoning shortfalls, most of the earlier medical opinions on the presence of legal pneumoconiosis also have diminished probative value. The recent assessments of Dr. Rasmussen and Dr. Rosenberg are reasoned and documented. However, as the best documented and similarly reasoned assessment, Dr. Castle's opinion is the more probative opinion on the issue of whether Mr. Dean has pneumoconiosis. As result, Dr. Rasmussen's diagnosis of legal pneumoconiosis is outweighed by Dr. Castle's more probative contrary conclusion, as supported by Dr. Rosenberg's conclusion that Mr. Dean does not have legal pneumoconiosis. Accordingly, absent a documentary basis for a diagnosis of clinical pneumoconiosis and since the preponderance of the more probative medical opinion indicates that Mr. Dean does not have legal pneumoconiosis, he is unable able to establish the presence of pneumoconiosis through medical opinion under 20 C.F.R. § 718.202 (a) (4).

Compton Analysis

Under the guidance of the decision in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), I must also consider both the chest x-ray evidence and medical opinion together to determine whether Mr. Dean has pneumoconiosis. In that regard, since standing alone neither the preponderance of the chest x-rays nor the more probative medical opinion establish the presence of pneumoconiosis, consideration of that evidence together obviously still fails to produce a finding of pneumoconiosis.

CONCLUSION

Based on the preponderance of the most recent arterial blood gas studies which met the total disability standards, Mr. Dean has established one of the condition of entitlement previously adjudicated against him in second, prior claim in March 2000. However, upon consideration of the entire record, I find the preponderance of the radiographic evidence is negative for pneumoconiosis. Further, the preponderance of the more probative medical evidence indicates Mr. Dean does not have pneumoconiosis. As a result, Mr. Dean is unable to establish the presence of pneumoconiosis through medical opinion. Accordingly, having failed to prove the first requisite element of entitlement, the presence of pneumoconiosis, Mr. Dean's third claim for black lung disability benefits must be denied.

ORDER

The modification request by MR. KENNETH R. DEAN is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: May 30, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

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